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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA
OAKLAND DIVISION

CALIFORNIA RESTAURANT ASSOCIATION,

Plaintiff,

-against-

THE CITY AND COUNTY OF SAN FRANCISCO, and THE SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Defendants.

CASE NO. CV-08-3247CW

BRIEF OF AMICI CURIAE CITY OF NEW YORK, THE NATIONAL ASSOCIATION OF COUNTY AND CITY HEALTH OFFICIALS, THE INTERNATIONAL MUNICIPAL LAWYERS ASSOCIATION, THE NATIONAL LEAGUE OF CITIES, THE NATIONAL ASSOCIATION OF LOCAL BOARDS OF HEALTH, MONTGOMERY COUNTY, MARYLAND, AND SAN MATEO COUNTY, CA.

Hearing Date: September 4, 2008
Time: 2:00 p.m.
Judge: Hon. Claudia Wilken
Place: Ctrm 2, 4th Floor

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PRELIMINARY STATEMENT

Amici Curiae, the City of New York, The International Municipal Lawyers Association, The National League of Cities, The National Association of Local Boards of Health, The National Association of County and City Health Officials, San Mateo County, California and Montgomery County, Maryland, respectfully submit this brief in support of the defendants, the City and County of San Francisco and the San Francisco Department of Health ("San Francisco").[1]

INTEREST OF AMICI CURIAE

In January 2008, in response to the growing obesity epidemic in New York City and the associated increase in the health problems related to obesity, the Department of Health and Mental Hygiene of the City of New York ("NYC Department of Health") adopted Health Code section 81.50. Restaurants which are one of a group of fifteen or more food service establishments offering for sale substantially the same menu items are required to post calorie information on their menus and menu boards.

The City of New York believes that its experience in implementing section 81.50 - the first to be implemented in the United States- may assist this Court in resolving the issues presented in plaintiff's motion for declaratory relief and a Preliminary Injunction. Further, the City has an interest in correcting assertions made by plaintiff herein, the California Restaurant Association, regarding the position taken by the City in the New York litigation challenging section 81.50.

[1] In an order entered July 23, 2008, this Court granted the City of New York leave to file an amicus brief on behalf of the City of New York and other governmental entities and associations.

The following amici who have signed onto this brief share a common interest in supporting San Francisco's effort to address the rapidly growing public health crisis of obesity by requiring disclosure of nutrition information for restaurant foods.

The National League of Cities ("NLC") is the country's largest and oldest organization serving municipal governments, with more than 1,600 direct member cities and 49 state municipal leagues that collectively represent more than 18,000 United States communities. Founded in 1924, NLC strengthens local governments through research, information sharing, and advocacy on behalf of hometown America.

The National Association of Local Boards of Health ("NALBOH") represents the interests of local boards of health in the United States. There are over 3,200 local boards of health across the United States with over 20,000 citizen volunteers working to improve the health of their communities. NALBOH's mission is to prepare and strengthen boards of health, empowering them to promote and protect the health of their communities through education, training, and technical assistance. NALBOH is dedicated to the development of effective public health policy at the community level.

The National Association of County and City Health Officials (NACCHO) is the national organization representing the approximately 2,860 local health departments nationwide. NACCHO's mission is to support efforts that protect and improve the health of all people and all communities by promoting national policy, developing resources and programs, seeking health equity, and supporting effective local public health practice and systems. NACCHO is the national voice and the national connection for local public health.

The International Municipal Lawyers Association ("IMLA") is a non-profit, nonpartisan, professional organization consisting of more than 2,500 members comprised of

local government entities, including cities and counties, and subdivisions thereof, as represented by their chief legal officers; state municipal leagues; and individual attorneys who represent municipalities, counties, and other local government entities.

Amicus Montgomery County has proposed restaurant nutrition legislation.

BACKGROUND FACTS

A. The New York City Litigation

In 2006, the NYC Department of Health adopted the predecessor to the present Health Code section 81.50. That predecessor section ("2006 HC 81.50") required restaurants which had already voluntarily published calorie information to post calorie amounts on menus and menu boards. The New York State ("NYS") Restaurant Association challenged the 2006 HC 81.50 on the grounds that it was preempted by the Nutrition Labeling and Education Act ("NLEA") and that it violated the First Amendment.

The United States District Court for the Southern District of New York (Holwell, U.S.D.J.) concluded "that the City has the power to mandate nutritional labeling by restaurants," but that 2006 HC 81.50 "offends the federal statutory scheme for voluntary nutritional claims" set forth in the NLEA and thus was preempted. *New York State Restaurant Ass'n v. New York City Board of Health*, 509 F. Supp. 2d 351, 352-53 (S.D.N.Y. 2007) ("NYSRA I"). The District Court held that the restaurants' voluntary act of making this calorie information available meant that these restaurants were making nutrient content claims governed by 21 U.S.C. § 343(r) and its preemption provision, and that 2006 HC 81.50 could thus not regulate how they were made. 509 F. Supp. 2d at 363. *See also*, 21 U.S.C. § 343-1(a)(5); 21 C.F.R. § 101.10.

In January 2008, the Board of Health repealed 2006 HC 81.50 and reenacted a new Health Code §81.50. Restaurants which are one of a group of fifteen or more food service

establishments offering for sale substantially the same menu items are required to post calorie information on their menus and menu boards. Unlike 2006 HC 81.50, the revised section 81.50 mandated the posting of calorie information on menus and menu boards by all covered restaurants and was not limited in its application to those restaurants which were already voluntarily disclosing the information in other forums, i.e., the internet.

The NYS Restaurant Association challenged this new provision on the grounds that it was preempted by the NLEA and that it violated the First Amendment. It sought declaratory relief on its preemption claim and preliminary injunctive relief on its preemption and First Amendment claims.

On April 16, 2008, the United States District Court for the Southern District of New York (Holwell, U.S.D.J.) granted the City's cross-motion for summary judgment on plaintiff's preemption claim and denied plaintiff's application for a preliminary injunction on its First Amendment claim (NYSRA II). *New York State Restaurant Association v. NYC Board of Health*, No. 08 Civ. 1000, 2008 U.S. Dist. LEXIS 31451, 2008 WL 1752455 (S.D.N.Y., Apr. 16, 2008).

The NYS Restaurant Association appealed and the United States Court of Appeals for the Second Circuit expedited the appeal. At the Court's request, the United States Food and Drug Administration ("FDA") filed a brief. As discussed in Point II, infra, contrary to plaintiff's argument herein, the City in the Second Circuit did not abandon the District Court's reasoning and the City's position was not inconsistent with the reasoning of the FDA in its brief.

On June 12, 2008, the appeal was argued and is presently *sub judice*. On June 16, 2008, the Second Circuit denied the NYS Restaurant Association's motion to stay the imposition of fines for violations of Section 81.50 pending determination of its appeal.

B. **States' Response to Soaring Obesity Rates.**

According to measured height and weight data from the National Health and Nutrition Examination Survey (NHANES), the obesity rate among U.S. adults more than doubled over the past three decades.[2] While 14.5 % of Americans were obese in 1971-1974, the proportion rose to 32.2 % by 2003-2004.[3] In the last decade, obesity rates have increased in *every* state in the nation.[4]

In response to this trend, in the last year, at least 14 states – Arizona, California, Connecticut, Hawaii, Illinois, Maine, Massachusetts, Michigan, New Jersey, New Mexico, New York, Pennsylvania, Tennessee, and Vermont– have introduced nutrition labeling legislation for restaurants.[5] Five other cities and counties – Chicago, Montgomery County, MD, Philadelphia,

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[2] Obesity is defined as a body mass index (BMI) of 30 or higher, or about 30 pounds overweight for a 5'4" person. BMI is a number calculated from a person's weight and height (kg / m^2) and is used to screen for weight categories that may lead to health problems.
Source: http://www.cdc.gov/nccdphp/dnpa/bmi/adult_BMI/about_adult_BMI.htm; accessed June 28, 2007.

[3] Ogden CL, Carroll MD, Curtin LR, McDowell MA, Tabak CJ, Flegal KM. *Prevalence Of Overweight And Obesity In The United States*, 1999-2004. JAMA 2006; 295:1549-1555.

[4] U.S. DEP'T OF HEALTH & HUMAN SERVS., *THE SURGEON GENERAL'S CALL TO ACTION TO PREVENT AND DECREASE OVERWEIGHT AND OBESITY* (2001), *available at* http://www.surgeongeneral.gov/topics/obesity/calltoaction/ CalltoAction.pdf.

[5] Senate Bill 1436, Arizona, 48th Legislature, First Regular Session (introduced 1/29/07); Senate Bill 1420, California, 2008-2009 Legislature (introduced 2/21/08); Senate Bill 686, Connecticut, January Session 2007 (introduced 4/11/07); House Bill 54, Hawaii 24th Legislature (introduced 1/18/07); House Bill 389, Illinois, 95th General Assembly, 2007-2008 Session (amended 3/20/07); Legislative Document 1774, Maine, 123rd Maine (3/29/07); Senate Bill 1290, Mass 185th Session (1/10/07); House Bill 4791, Michigan 94th Legislature, Regular Session (5/17/07);Assembly Bill 1407, New Jersey, 213th Legislature, 2008 Session (1/8/08); House Bill 1203, Mexico, 48th Legislature, First Session (2/26/07); Assembly Bill 729, New York State, 2007-2008 Regular Session (1/3/07); Senate Bill 3787, New York 2007-2008 Regular Session (3/16/07); House Bill 1108, Pennsylvania 2007-2008 Session (4/18/07); Senate Bill 1696,

Washington D.C., and Westchester County, NY – have introduced nutrition labeling legislation.[6] In addition to New York City and San Francisco, Santa Clara County, CA. and King County, WA have adopted restaurant nutrition labeling legislation.[7]

The increase in the rate of obesity in just these states which have introduced legislation highlights the seriousness of the problem. Since 1991, the percentage of obese adults in these states increased as follows:

- Arizona – doubled to 25%
- California – doubled to 23%
- Connecticut – nearly doubled to 21%
- Hawaii – nearly doubled to 21%
- Illinois – doubled to 25%
- Maine – doubled to 24%
- Massachusetts – nearly tripled to 21%
- Michigan – nearly doubled to 27%
- New Jersey – nearly tripled to 23%
- New Mexico – nearly tripled to 24%
- New York – doubled to 25%
- Pennsylvania – doubled to 27%
- Tennessee – nearly tripled to 30%
- Vermont – nearly doubled to 21%[8]

Tennessee 105th General Assembly (2/8/07); House Bill 477, Vermont 2007-2008 Session (3/1/07); Senate Bill 6505.

[6] Ordinance 2008-1841, Chicago City Council (introduced 3/12/08); Bill 080167, Philadelphia City Council (introduced 2/14/08); Bill 19-07, Montgomery County (MD) City Council (7/31/07); Bill 17-0139, Council of Washington, DC (3/6/07); Chapter 708, Board of Legislators of Westchester County, New York (1/22/08).

[7] Board f Health Regulation 08-02, King County, WA. (adopted 4/17/08); Board of Supervisors of the County of Santa Clara, CA, Ordinance No. NS-300.793 (effective 9/1/08).

[8] Centers for Disease Control and Prevention (CDC), U.S. Dep't of Health & Human Servs., U.S. Obesity Trends 1985-2007, http://www.cdc.gov/nccdphp/dnpa/obesity/trend/maps/index.htm. (follow "PowerPoint slide presentation format" hyperlink); CDC, U.S. DEP'T OF HEALTH AND HUMAN SERVS., BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM SURVEY DATA (2006), http://apps.nccd.cdc.gov/brfss/.

When the number of people who are overweight is added to those who are obese, the figures are even more staggering. In Arizona, New Jersey and New Mexico, at least 60% of adults are overweight or obese. In Michigan and Tennessee, 65% of adults are obese or overweight. In Massachusetts, the state with the *lowest* rate among the fifteen states, 56% of adults are obese or overweight.[9]

The statistics for individual cities and counties are similarly alarming. In three of the cities that have introduced nutrition labeling legislation in the last year – Chicago, Philadelphia, and Washington D.C. – more than 55% of adults were obese or overweight as of 2006.[10] In Los Angeles County, 57% of adults were overweight or obese as of 2005, and 23% of school children were obese.[11]

C. **The Burden That The Obesity Crisis Places On States And Localities.**

People who are overweight or obese are at increased risk for type 2 diabetes, heart disease, stroke, arthritis, gall bladder disease, osteoarthritis, sleep apnea, respiratory problems, depression, and colon, breast, endometrial, and prostate cancers. As of 2005, 15.8 million

[9] CDC, BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM SURVEY DATA, *supra* note 8.

[10] Prevalence rates of obesity and overweight in those metropolitan areas were as follows: Chicago, 61%; District of Columbia, 59%; Philadelphia, 57%. *See* CDC, BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM SURVEY DATA, *supra* note 8.

[11] LOS ANGELES COUNTY DEP'T OF PUBLIC HEALTH, 2005 LOS ANGELES COUNTY HEALTH SURVEY (2005), *available at* http://www.lapublichealth.org/ha/ docs/bmi2005.xls; SIMON ET AL., LOS ANGELES COUNTY DEP'T OF PUBLIC HEALTH, MENU LABELING AS A POTENTIAL STRATEGY FOR COMBATING THE OBESITY EPIDEMIC (2008), *available at* http://www.lapublichealth.org/docs/Menu_Labeling_Report_2008.pdf.

Americans had diabetes, almost triple the number from 1980.[12] Between 50% and 80% of diabetes cases are associated with obesity, unhealthy eating and physical inactivity.[13]

Obesity and overweight in adulthood are associated with large decreases in life expectancy.[14] A 2005 study by the Centers for Disease Control and Prevention (CDC) estimated that approximately 112,000 deaths are associated with obesity each year in the United States, making obesity the second leading contributor to premature death, behind only tobacco.[15]

This epidemic is also generating extraordinary financial costs to society. A 2002 study by the American Diabetes Association estimates that direct and indirect costs of diabetes were $132 billion.[16] These sums are far larger if other obesity-related diseases and lost productivity are taken into account. Health care spending among people who are obese has been estimated to be 37% higher than among those with normal weight, and increases in the proportion of and spending on obese people relative to people of normal weight accounted for 27% of the rise in inflation-adjusted per capita health care spending between 1987 and 2001.[17]

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[12] NAT'L CTR. FOR HEALTH STATISTICS, CDC, NAT'L DIABETES SURVEILLANCE SYSTEM, PREVALENCE OF DIABETES (1980-2005), http://www.cdc.gov/diabetes/statistics/prev/national/tablepersons.htm.

[13] F.B. Hu, et al., *Diet, Lifestyle, and the Risk of Type 2 Diabetes Mellitus in Women*, 345 NEW ENGLAND J. MED. 790-97 (2001).

[14] Peeters A, Barendregt JJ, Willekens F, Mackenbach JP, Al Mamun A, Bonneux L. *Overweight And Obesity By Middle Age Are Associated With A Shortened Lifespan*. Ann Intern Med 2003; 138:24-32.

[15] Katherine M. Flegal et al., *Excess Deaths Associated with Underweight, Overweight, and Obesity*, 293 J. AM. MED. ASS'N 1861, 1861-67 (2005).

[16] American Diabetes Assn., *Economic Costs of Diabetes in the U.S. in 2002*.Diabetes Care, v.26, n.3. March 2003.

[17] Thorpe KE, Florence CS, Howard DH, Joski P. *The Impact Of Obesity On Rising Medical Spending*. Health Aff (Millwood). 2004 Jul-Dec;Suppl Web Exclusives:W4-480-6.

State governments pay a large portion of the health care costs associated with the obesity epidemic. In the fourteen states that have introduced nutrition disclosure legislation, their annual medical expenditures attributable to obesity from state Medicare and Medicaid funds are estimated as follows:

- Arizona – $396 million
- California – $3.5 billion
- Connecticut – $665 million
- Hawaii – $120 million
- Illinois – $1.8 billion
- Maine – $203 million
- Massachusetts – $1.1 billion
- Michigan – $1.6 billion
- New Jersey – $1.2 billion
- New Mexico – $135 million
- New York – $4.9 billion
- Pennsylvania – $2.4 billion
- Tennessee – $921 million
- Vermont – $69 million[18]

POINT I

RESTAURANT NUTRITION DISCLOSURE LEGISLATION IS SOUND PUBLIC POLICY AND REFLECTS A NATIONAL CONSENSUS SHARED BY THE FDA AND HEALTH EXPERTS THAT PROVIDING CUSTOMERS WITH THE INFORMATION THEY NEED TO MAKE HEALTHFUL EATING CHOICES IS A USEFUL STRATEGY IN REDUCING OBESITY.

Although the California Restaurant Association argues that there is no evidence that menu labeling requirements will have likely health benefits, the U.S. Surgeon General, the FDA, and the Institute of Medicine have all recommended nutritional labeling of restaurant foods

[18] Eric A. Finkelstein et al., *State-Level Estimates Of Annual Medical Expenditures Attributable To Obesity*, 12 Obesity Research 18, 22-23 (2004).

as a useful strategy for addressing obesity. Further, as discussed below, nutritional labeling for restaurant foods is sound public policy because (1) an increasing proportion of calories is being consumed away from home; (2) presently people underestimate calories; (3) evidence indicates that consumers want nutritional information and will use it to make food choices; and (4) making calorie information readily accessible to diners will likely result in the development of healthier menu offerings.

A. Leading Scientific Authorities Recommend That Calorie Information Be Readily Available In Restaurants, Including At Point Of Purchase

The California Restaurant Association's argument that more research should be conducted before localities and states take action to curb the obesity epidemic is contrary to the recommendation of the scientific community. For example, the Institute of Medicine concluded in its 2004 report on childhood obesity that because "[t]he obesity epidemic is a serious public health problem calling for immediate reduction in obesity prevalence and in its health and social consequences, … actions should be based on the best available evidence—as opposed to waiting for the best possible evidence."[19]

Additionally, the final report of the FDA-commissioned Keystone Forum on Away-From-Home Foods recommends that: "Away-from-home food establishments should provide consumers with calorie information in a standard format that is easily accessible and easy to use."[20] This was the *first* recommendation in Chapter 4 of the report, "Providing

[19] Institute of Medicine. *Preventing Childhood Obesity: Health in the Balance* (Jeffrey P. Coplan et al. eds., 2004).

[20]The Keystone Center. The Keystone Forum on Away-From-Home Foods: Opportunities for Preventing Weight Gain and Obesity. Final Report. May 2006. Washington, D.C. [Report commissioned by the U.S. Food and Drug Administration.] URL: http://www.keystone.org/spp/documents/Forum_Report_FINAL_5-30-06.pdf. A copy of the

Consumers with Nutrition Information." Putting calorie information on menus and menu boards is consistent with this recommendation. As the report noted when providing operational tips for accomplishing its recommendation:

> Information should be provided in a manner that is easy for consumers to see and use as part of their purchasing and eating decisions. Consumer might view such information, for example, when standing at a counter, while reviewing a menu board, in a car when reading a drive-through menu, or when sitting down at a table reviewing a menu, a table tent, or others means of providing information.

Id. at 77.

The California Restaurant Association cites other parts of the report, such as the desirability of further research, but omits the report's conclusion that "while the knowledge base needs to be improved, enough is known to recommend many important actions. . . . reasonable strategies to assist consumers with healthy energy intake *should be pursued now*, and then augmented going forward as new information becomes available." Id. at 29 (emphasis added).

In addition to the FDA Keystone Forum report, the Institute of Medicine, the Surgeon General, and the President's Cancer Panel, have recommended that nutrition information be available in restaurant settings, to address the nation's obesity epidemic, including at the point of purchase. The Institute of Medicine recommended that: **"**Fast-food and full-service restaurants should expand healthier meal, food, and beverage food options (including children's meals) and provide calorie content and general nutrition information at point of

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Report is annexed as Exhibit "F" to the Appendix filed by California Restaurant Association with its Motion for Declaratory and Injunctive Relief.

purchase."[21] The Surgeon General of the United States has called for industry to "increase availability of nutrition information for foods eaten and prepared away from home."[22] The 2006-2007 report of the President's Cancer Panel, in light of the increasing contribution of obesity to cancer, recommends: "Make nutrition information on restaurant foods readily available on menus and understandable to consumers."[23]

B. **An Increasing Proportion of Calories Is Being Consumed Away From Home**

Eating out, and eating extra calories while eating out, contributes disproportionately to the excess calorie intake that fuels the obesity epidemic.[24,25] Increasingly, Americans are eating meals away from home. In 1970, Americans spent 26% of their food dollars on foods prepared outside their homes, while by 2006, they spent almost half (48%) of their food dollars eating out.[26]

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[21] Institute of Medicine of the National Academies. *Industry Can Play A Role In Preventing Childhood Obesity. Fact Sheet 2004*. Drawn from Preventing Childhood Obesity, Health in the Balance 2005. Accessed at www.iom.edu on February 2, 2008.

[22] U.S. Department of Health and Human Services. *The Surgeon General's Call To Action To Prevent And Decrease Overweight And Obesity*. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General.

[23] President's Cancer Panel. *Promoting Healthy Lifestyles. Policy, Program and Personal and Recommendations for Reducing Cancer Risk. 2006-2007.* Annual Report. U. S. Department of Health, National Institutes of Health, National Cancer Institute. Bethesda, Maryland, 2007.

[24] St-Onge MP, Keller KL, Heymsfield SB. *Changes In Childhood Food Consumption Patterns: A Cause For Concern In Light Of Increasing Body Weights*. American Journal of Clinical Nutrition 2003; 78:1068-1073

[25] French SA, Harnack L, Jeffery RW. *Fast Food Restaurant Use Among Women In The Pound Of Prevention Study: Dietary, Behavioral And Demographic Correlates*. International Journal of Obesity *2000*. 24:1353-1359.

[26] FDA Keystone Report, supra, note 20, at 122.

Children eat almost twice as many calories when they eat out than when they eat at home.[27] This trend has been facilitated by the increasing number of chain restaurants, which serve food that is easily available, inexpensive and high in calories. Nationally, restaurant chains – both fast food and casual dining chains – comprise a growing share of customer traffic. Between 2005 and 2009, the number of fast food establishments is projected to increase from 266,300 to 287,437 establishments.[28]

Moreover, studies have documented patterns of increasing portion sizes, particularly at fast-chain restaurants, since the 1970s, in a pattern that parallels the epidemic of obesity.[29,30,31,32,33] There is abundant data to show that people who eat at fast food establishments consume more calories. Two important analyses draw on the Continuing Surveys of Food Intakes conducted in the mid 1990s. The first, a 1994-1996 survey of 17,370 adults and children, found that adults who ate at fast food restaurants consumed 205 more calories per day than those

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[27] Zoumas-Morse C. et al., *Children's Patterns of Macronutrient Intake and Associations with Restaurant and Home Eating*., Journal of the American Dietetic Association 2001. 101:923-925.
[28] C. Barnes & Co. 2008 Barnes reports: U.S. Fast Foods Restaurants Industry (NAICS 72221).

[29] Nielsen, S. J., and B. M. Popkin. *Patterns And Trends In Food Portion Sizes*, 1977-1998. JAMA 2003; 289(4):450-453.

[30] Young, L. R. and M. Nestle. *The Contribution of Expanding Portion Sizes to the US Obesity Epidemic*, American Journal of Public Health 2002; 92(2):246-249.

[31] Guthrie, J. F., B. H. Lin, and E. Frazao. *Role Of Food Prepared Away From Home In The American Diet, 1977-78 Versus 1994-96: Changes And Consequences.* Journal of Nutrition Education and Behavior 2002; 34(3):140-150.

[32] Ello-Martin, J. A., J. H. Ledikwe, and B. J. Rolls. *The Influence of Food Portion Size and Energy Density on Energy Intake: Implications for Weight Management.* The American Journal of Clinical Nutrition 2005; 82(1 Suppl.):236S-241S.

[33] Young L.R. and Nestle M. *Portion Sizes and Obesity: Responses of Fast-Food Companies.* Journal of Public Health Policy 2007; 28: 238–248.

who did not, and children ate 155 more calories.[34] In the second survey, of more than 9,000 adults, mean energy intake on days when fast food was consumed was 206 calories higher than on other days.[35] In the second survey, fast food contributed more than one third of consumers' daily calorie intake.[36] Similarly, in a study of nearly 900 women, called Pound of Prevention, increased frequency of eating at fast food restaurants was associated with higher total energy intake.[37] This association has also been shown among adolescents and children. A study of 4,746 students age 11-18 years found that regular fast food consumption was associated with 800 extra calories per week in boys and 660 extra calories per week in girls.[38] Such a calorie excess could translate into a weight gain of 10 pounds or more per year. An increase of 129 calories per day among high- versus low-frequency consumers of fast food was also reported in a large national cohort of adolescent girls.[39]

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[34] Paeratakul S, Perdinand D, Champagne C, Ryan D, Bray G. *Fast-Food Consumption Among US Adults And Children: Dietary And Nutrient Intake Profile.* Journal of American Dietetic Association 2003; 103(10):1332-1338.

[35] Bowman S, Vinyard B. *Fast Food Consumption Of US Adults: Impact On Energy And Nutrient Intakes And Overweight Status.* Journal of the American College of Nutrition 2004; 23(2):163-168.

[36] Bowman S, Vinyard B. *Fast Food Consumption Of US Adults: Impact On Energy And Nutrient Intakes And Overweight Status.* Journal of the American College of Nutrition 2004; 23(2):163-168.

[37] French SA, Harnack L, Jeffery RW. *Fast Food Restaurant Use Among Women In The Pound Of Prevention Study: Dietary, Behavioral And Demographic Correlates*. International Journal of Obesity 2000. 24:1353-1359.

[38] French SA, Story M, Neumark-Sztainer D, Fulkerson JA & Hannan P. *Fast Food Restaurant Use Among Adolescents: Associations With Nutrient Intake, Food Choices And Behavioral And Psychosocial Variables*. International Journal of Obesity, 2001; 25: 1823-33.

[39] Schmidt M, Affenito SG, Striega-Moore R, Khoury PR, Barton B, Crawford P, Kronsberg S, Schreiber G, Obarzanek E, Daniels S. *Fast-food intake and diet quality in black and white girls:*

C. **People Consistently Underestimate The Number Of Calories Consumed**

Consumers consistently underestimate the calorie content of food items and overestimate the healthfulness of restaurant items.[40] As the FDA-commissioned Keystone Report concluded, "[w]ithout nutrition information, consumers typically are unable to assess the caloric content of foods." FDA Keystone Report, supra, note 20, at 68, 73. Recent studies found that 9 out of 10 people underestimated the calorie content of less-healthy items, and that they did so by an average of more than 600 calories (almost 50% less than the actual calorie content).[41]

Even experienced nutrition professionals have difficulty accurately estimating the calorie content of restaurant food. In one study, while these professionals could accurately describe the calories in a cup of milk, they generally underestimated calories in restaurant food by 200 to 600 calories. If not even experienced professionals in the field of nutrition are able to accurately estimate the calorie content of restaurant foods, consumers are even less likely to do so.[42]

D. **Current Nutrition Information Practices Are Woefully Inadequate**

The current nutrition information practices of chain restaurants do not effectively transmit calorie information to consumers. Some chains fail to provide any nutrition information

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the National Heart, Lung, and Blood Institute Growth and Health Study. Archives of Pediatrics & Adolescent Medicine 2005; 159(7):626-631.

[40]Burton S, Creyer EH. *What Consumers Don't Know Can Hurt Them: Consumer Evaluations And Disease Risk Perceptions Of Restaurant Menu Items.* The Journal of Consumer Affairs. 2004; 38(1):121-145.

[41]Burton S, Creyer EH. et al. *Attacking The Obesity Epidemic: The Potential Health Benefits Of Providing Nutrition Information In Restaurants.* Am J Public Health. 2006; 96(9):1669-1675.

[42]J. Backstrand, et al., *Fat Chance* (Washington, DC: Center for Science in the Public Interest, 1997).

to consumers. As described in the declarations submitted by the California Restaurant Association, chain restaurants do not typically display nutritional information where and when consumers make their choices and purchases. Such information is typically displayed only where it is hard to find, difficult to read, or accessible only after a purchase is made. Thus, the provided information has little or no impact on choice. While a number of chain restaurants offer nutrition information on their websites, "[l]ooking up nutritional information on a restaurant's food offerings on line before visiting the restaurants requires, at the very least, Internet access and advance planning." Rebecca S. Fribush, *Putting Calorie and Fat Counts on the Table: Should Mandatory Nutritional Disclosure Laws Apply to Restaurant Foods?*, 73 Geo. Wash. L. Rev. 377, 385 (2005). Similarly, while some chain restaurants have nutritional information posted on materials like napkins or tray liners, such items are "not likely to be distributed to consumers until after they have already made their purchasing decisions." *Id.; see also*, *See* Michael M. McCann, *Economic Efficiency and Consumer Choice Theory in Nutritional Labeling*, 2004 Wis. L. Rev. 1161, 1198 (2004).

E. Consumers Want Calorie Information And Will Use It To Make More Informed Choices.

Since 1994, the NLEA has made nutrition information available to consumers on packaged foods purchased in retail stores. This information is widely used, with three quarters of American adults reporting that they examine food labels,[43] the calorie section is the most frequently consulted part of the Nutrition Facts panel on packaged foods, with 73% of consumers

[43] US Department of Health and Human Services (US DHHS), Centers for Disease Control and Prevention, *National Center for Health Statistics. Healthy People 2000 Final Review. 2001.*

reporting that they look at calorie content.[44] Nearly half (48%) of those who consult the nutrition information on packaged foods report changing their food purchasing habits as a result of reviewing this information.[45]

Similarly, consumers are interested in knowing the calorie content of restaurant foods and will use it to make more informed choices. Six nationally representative polls have found that 62% to 87% of Americans support requiring restaurants to list nutrition information.[46,47] In studies where calorie information is provided, consumers choose high-calorie items 24% to 37% less often.[48] A NYC Department of Health exit interview and receipt study conducted in May and June 2007 demonstrated that patrons of Subway who saw calorie information at the point of purchase chose items with fewer calories.[49] At the time of the study, Subway – NYC's second-largest chain, with 315 restaurants – posted nutritional information for some of its products on a sticker placed on a display case near the cash register – a manner far

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[44] International Food Information Council (IFIC) Foundation. *Food & Health Survey: Consumer Attitudes Toward Food, Nutrition & Health.* Washington, DC: 2007.

[45] Levy AS. Derby BM. *The Impact Of NLEA On Consumers: Recent Findings From FDA's Food Label And Nutrition Tracking System.* Washington DC: Center for Food Safety and Applied Nutrition. Food and Drug Administration. 1996.

[46]Center for Science in the Public Interest. *Anyone's Guess: The Need For Nutrition Labeling At Fast-Food And Other Chain Restaurants.* Washington, DC: Center for Science in the Public Interest, 2003.

[47] Harvard Forums on Health. *Obesity as a Public Health Issue: A Look at Solutions. National Poll by Lake, Snell, Perry & Associates. June 2003*.

[48] Burton S, Creyer EH, Kees J, Huggins K. *Attacking The Obesity Epidemic: The Potential Health Benefits Of Providing Nutrition Information In Restaurants*. Am J Public Health. 2006; 96:1669-1675.

[49]Bassett, M. *Purchasing Behavior and Calorie Information at Fast-Food Chains in New York City, 2007*. American Journal of Public Health 2008, Vol. 98, No. 8, pp. 1-3.

less prominent than that mandated by NYC Health Code §81.50. Nevertheless, among the 1,830 Subway patrons sampled at 47 randomly selected Subway locations, nearly one third (30.8%) reported seeing the calorie information. Further, patrons who saw calorie information purchased items containing 52 fewer calories than patrons who did not see it. Furthermore, patrons who acknowledged that calorie information had affected their selection were correct – they chose items with 99 fewer calories, a statistically significant finding. That their self-report of use of calorie information matched the data from their receipts that documented lower-calorie choices is consistent with findings that when consumers say they will change choices based on calorie information, they often actually do so. These findings strengthen earlier evidence[50] on changes in purchase intent when people see calorie information by actually documenting changes in what people buy after seeing calorie information.

Additionally, a 2005 study of college students found that providing nutrition information at the point of sale in campus dining facilities had a positive influence on their food purchasing behavior [51] Similarly, another study found a significant decrease in the number of calories that people purchase when signs indicating the calorie content of available foods were posted in a cafeteria setting.[52]

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[50] Burton S, Creyer EH, Kees J, Huggins K. *Attacking The Obesity Epidemic: The Potential Health Benefits Of Providing Nutrition Information In Restaurants*. Am J Public Health. 2006; 96:1669-1675.

[51] Martha T. Conklin, et al., *College Students' Use of Point of Selection Nutrition Information*, 2 TOPICS IN CLINICAL NUTRITION 20, 97, 97-108 (2005).

[52] R. Milich, et al., *Effects of Visual Presentation of Caloric Values on Food Buying by Normal and Obese Persons*, 42 PERCEPTUAL AND MOTOR SKILLS 155, 155-162 (1976).

Nutrition information at point of sale in restaurants can have an impact even if not all patrons make use of the information. The DeMuth declaration[53] submitted by the California Restaurant Association cites Krukowski's report[54] that 44-57% of students in a study said that they were not likely to use food caloric information as an argument against calorie posting. Yet, conversely 43-56% of patrons in that same study stated that they *would* use nutrition information if it were available, suggesting that calorie posting will have a substantial effect on public health.

As set forth in the declaration of Mary Bassett, Deputy Commissioner, Health Promotion and Disease Prevention of the NYC Department of Health, dated July 30, 2008 ("Bassett Declaration"), there has been a positive consumer response to the implementation of section 81.50.

F. Making Calorie Information Readily Accessible To Diners Will Likely Result In The Development Of Healthier Menu Offerings

In addition to providing consumers with the necessary information to make healthier choices, calorie posting will motivate the food service industry to improve its menu offerings. According to the FDA-sponsored Keystone Forum, "A key benefit of mandatory nutrition labeling on packaged foods has been the reformulation of existing products and the introduction of new, nutritionally improved products. Between 1991 (before the implementation of the NLEA) and 1995 (after implementation) the number of fat-modified cheeses has tripled, and market share for fat-modified cookies increased from zero percent of the market to 15%. In a

[53] The DeMuth declaration is annexed as Exhibit B to the California Restaurant Association's Motion.

[54] Krukowski RA, Harvey-Berino J, Kolodinsky J, Narsana RT, Desisto TP. *Consumers May Not Use Or Understand Calorie Labeling In Restaurants*. J Am Diet Assoc 2006; 106(6):917-20.

similar fashion, nutrition labeling on menus and menu boards may spur nutritional improvements in restaurant foods." Keystone Report, *supra*, note 20, at 73**.**

As discussed in the Bassett Declaration, since section 81.50 has been implemented, many restaurants have reformulated some of their menu items to lower calorie counts.

G. **In Sum, Nutrition Labeling Legislation Is Sound Public Policy .**

As discussed above, there is a consensus among health experts who have addressed the obesity crisis, including the FDA, that restaurant nutrition disclosure legislation is a sound and reasonable strategy to combat the problem. Thus, this Court should not invalidate San Francisco Ordinance 40-08.

POINT II

CONTRARY TO THE CALIFORNIA RESTAURANT ASSOCIATION'S ARGUMENT, THE POSITION TAKEN BY THE CITY OF NEW YORK IN THE NYSRA II APPEAL WAS FULLY CONSISTENT WITH THE REASONING OF THE DISTRICT COURT IN NYSRA II AND WITH THE POSITION TAKEN BY THE FDA.

In an attempt to undermine the well-reasoned decision of the District Court for the Southern District of New York in NYSRA II, and the FDA's position that state nutrition disclosure legislation of restaurant foods is not preempted, the California Restaurant Association argues that on appeal, the City "effectively abandoned" the District Court's reasoning. Additionally, it argues that the City's position is different from that of the FDA's. (Cal. Rest. Assoc. Memorandum of Points, at page 10) As discussed below, this is a complete mischaracterization of the City's position.

Moreover, the California Restaurant Association's argument is an attempt to distract this Court from the dispositive issue herein- whether Congress in enacting the NLEA intended to take away the states' historical power to regulate restaurants. Congress explicitly indicated that the preemption provisions in the NLEA are to be read narrowly. The NLEA specifically provides that it "shall not be construed to preempt any provision of state law, unless such provision is expressly preempted under section 403A [21 U.S.C. §343-1(a)] of the Federal Food, Drug, and Cosmetic Act." Pub. L. No. 101-535, §6(c), 104 Stat. 2535, 2364. Thus, in order to find preemption, the Court would have to find that the preemption of state menu labeling legislation was expressly required by the statute.

The basic nutrition labeling authority is contained in 21 U.S.C. § 343(q), where Congress directed the FDA to impose mandatory nutrition labeling requirements on most food. Nevertheless, in 21 U.S.C. § 343(q)(5)(A)(i) the statute explicitly exempted restaurants from those labeling requirements. In the applicable preemption section of the statute, section 343-1(a)(4), Congress included parallel provisions. Thus in the first portion of section 343-1(a)(4), the statute preempts the states from establishing any requirement "that is not identical" to a requirement under (q), but in the second portion of that same provision, it states that the preemption shall not apply to "a requirement for nutrition labeling of food which is exempt under subclause (i) of section [343](q)(5)(A)." Subclause (i) exempts restaurants from the federal nutrition labeling requirements.

Thus, the statute explicitly states that the preemption provision does not apply to nutrition information regarding restaurants. The FDA, the expert agency charged with interpreting the NLEA, has adopted this same interpretation of the statute. The FDA's interpretation is entitled to deference because it is completely consistent with the statute. *See,*

e.g., Chervon USA, Inc. v. Natural Resources Defense Council, 467 U.S. 837 (1984) (the Court will uphold the agency's interpretation if it is based on a permissible construction of the statute); *Skidmore v. Swift & Co.*, 323 U.S. 134, 140 (1944) (agency interpretations "constitute a body of experience and informed judgment to which courts and litigants may properly resort for guidance").

The California Restaurant Association's argument that the FDA's position is not entitled to deference because it is inconsistent with section 101.13(b)(1) of the FDA's regulations is meritless. The FDA does not interpret the cited regulation as broadly as plaintiff does. See *Auer v. Robbins*, 519 U.S. 452, 461 (1997) (when an agency is interpreting its own regulation, its interpretation is "controlling unless plainly erroneous or inconsistent with the regulation"). Moreover, if the FDA adopted such a broad interpretation of the regulation, it would be inconsistent with the statute and would not be entitled to deference**.** See, *Desiano v. Warner-Lambert & Co.,* 467 F.3d 85, at 97, fn. 9 (2d Cir. 2007), *aff'd*, 128 S. Ct. 1168 (2008) (equally divided court) ("whatever deference would be owed to an agency's view in contexts where a presumption against federal preemption does apply, an agency cannot supply, on Congress's behalf, the clear legislative statement of intent required to overcome the presumption against preemption").

In its brief filed in the Second Circuit, the FDA indicated that the mandatory/voluntary distinction was not dispositive, but rather was one prong of the inquiry in determining whether the legislation involved 343(r) claims or 343(q) nutrition information.. The second inquiry looked at the type of information which was required to be disclosed. (FDA brief, annexed to Declaration of Tara Steeley as Exhibit "2", at pp. 20-21). This is the FDA's sole "disagreement" with the District Court opinion.

The District Court, however, also recognized that the mandatory/voluntary distinction was not dispositive. Indeed, the determination whether the legislation involved 343(r) claims or 343(q) nutrition information is a two-part inquiry. Whether the disclosure is mandated is only one prong of the inquiry; the other prong is whether the information is 343(q) type information. The preemption provision, 343-1(a)(5), prevents a state or local government from mandating that restaurant include § 343(r) content claims (i.e. "low calorie"). In contrast, it is clear that under the NLEA, local governments can mandate § 343(q) type information such as the number of calories contained in a particular food item. The District Court in NYSRA II stated:

> There is a world of difference … between the qualitative statement "low in fat" and the quantitative statement "100 calories." The latter is clearly an unadorned statement of fact that is contemplated by § 343(q) to be disclosed on a food label. And in the absence of federal regulation, it is precisely this type of disclosure that states may mandate. On the other hand, the statement "low in fat" characterizes the level of a nutrient and would be subject to regulation under § 343(r) when voluntarily made. Even if mandated, it would not escape the reach of § 343(r) for the added reason that only "statement of the type required by paragraph (q)" is exempt from regulation under subsection (r). 21 U.S.C. § 343(r). "Low in fat is not such a statement.

2008 WL 1752455, *5(emphasis added).

The City adopted the District Court's reasoning in its brief in the Second Circuit, quoting the above reasoning. Thus, contrary to the California Restaurant Association's assertion, although there may be nuances in the positions taken by the City and the FDA, we are in agreement that two factors are necessary to the analysis, specifically, (1) whether the disclosure is mandated and (2) what type of information is mandated to be disclosed?

CONCLUSION

For the reasons stated above and in the defendant's brief, this Court should deny plaintiff's motion for declaratory and preliminary injunctive relief.

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Respectfully submitted,

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